

# HEALTH CARE REFORM POLICY DOCUMENTATION

## RENEWAL

<b>This policy applies to:</b>	<input checked="" type="checkbox"/> MAGI Medicaid <input checked="" type="checkbox"/> Cost Sharing Reductions <input checked="" type="checkbox"/> Non-MAGI Medicaid <input checked="" type="checkbox"/> Qualified Health Plans (QHP) <input checked="" type="checkbox"/> Advanced Premium Tax Credits <input type="checkbox"/> Individual Insurance Requirement Exemption
<b>Does this document reflect a change in policy?</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

<b>Document Scope:</b>	Identify general overview policies associated with renewal processing
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DEFINITIONS		
Term	Definition	Comments
Renewal	The process of redetermining eligibility at the end of an enrollee's certification period.	

'AS IS' POLICY ASSESSMENT OF CURRENT POLICY	
Current Citations <small>List citation and link to underlying authority or embedded PDF</small>	Plain Language Synopsis of Citations
42 CFR <a href="#">435.908</a>	The agency must allow an individual or individuals of the applicant's choice to accompany, assist, and represent the applicant in the application process or a redetermination of eligibility.
42 CFR <a href="#">435.916</a>	<p>(a) The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months, however—</p> <p>(1) The agency may consider blindness as continuing until the review physician under § 435.531 determines that a recipient's vision has improved beyond the definition of blindness contained in the plan; and</p> <p>(2) The agency may consider disability as continuing until the review team under § 435.541 determines that a recipient's disability no longer meets the definition of disability contained in the plan.</p> <p>(b) Procedures for reporting changes. The agency must have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility.</p> <p>(c) Agency action on information about changes. (1) The agency must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility.</p> <p>(2) If the agency has information about anticipated changes in a recipient's circumstances, it must redetermine eligibility at the appropriate time based on those changes.</p>
42 CFR <a href="#">435.930</a>	<p>The agency must—</p> <p>(a) Furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures;</p> <p>(b) Continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible; and</p> <p>(c) Make arrangements to assist applicants and recipients to get emergency medical care whenever needed, 24 hours a day and 7 days a week.</p>
Minn. Stat. § <a href="#">256B.056, subd. 5a</a>	Recipients of medical assistance who receive only fixed unearned or excluded income, when that income is excluded from consideration as income or unvarying in amount and timing of receipt throughout the year, shall report and verify their income annually.
Minn. Stat. § <a href="#">256B.056, subd. 5b</a>	Recipients of medical assistance not residing in a long-term care facility who have slightly fluctuating income which is below the medical assistance income limit shall

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	report and verify their income on a semiannual basis.
Minn. Stat. § <a href="#">256B.056 subd. 7</a>	A redetermination of eligibility must occur every 12 months
Minn. Stat. § <a href="#">256B.056, subd. 10(c)</a>	The commissioner shall verify assets and income for all applicants, and for all recipients upon renewal.
Minn. Rules, part <a href="#">9505.0095</a>	The local agency must not require an applicant or recipient to verify more than once an eligibility factor not subject to change and available in existing medical assistance files of the local agency.
Minn. Rules, part <a href="#">9505.0115</a>	Applicants and recipients must report a change of circumstances within ten days of learning about the change. The county must redetermine eligibility when a change is reported.

### Current Policy

MA enrollees who do not meet an annual renewal exemption must submit an annual renewal.

- Individuals exempt from annual renewals include:
  - Pregnant women
  - People receiving Transitional MA or Transition Year MA
  - Recipients of Title IV-E or state adoption assistance
  - Auto newborns
- MA enrollees who do not meet a six-month renewal exemption must submit a six-month renewal.
- Individuals exempt from six-month asset renewals include:
  - People exempt from asset limits
  - People exempt from six-month income renewals.
- Individuals exempt from six-month income renewals include:
  - People who submit monthly renewals for MA, Food Support, or cash assistance.
  - People who meet an annual renewal exemption
  - People who receive only unvarying unearned income
  - People who receive only excluded income
  - Refugee Medical Assistance enrollees
  - People who report no income
- For six-month renewals, countable assets and current income must be verified.
- Certain individuals are exempt from six-month asset or income renewals.
- Certain individuals with a long-term care spenddown are required to renew eligibility monthly.
- The first annual renewal month is 12 months after the first month of the certification period.
- Subsequent annual renewal months are 12 months following the effective date of the last annual renewal month
- Signatures on renewal forms are required from all enrollees age 18 or older or from individuals age 18 or older who are applying for coverage on the renewal.

## 1. MA Renewals

This section describes specific requirements for MA annual, six-month and monthly renewals.

### MA Renewal Requirements

There are three types of renewals MA enrollees may be required to submit depending on their circumstances. They are:

- An annual renewal.
  - Enrollees who do not meet an [annual renewal exemption](#) must complete an annual renewal every 12 months.
  - Renewals must be processed by the end of the month before the annual [renewal month](#) for eligibility to continue.
- [Six-month renewal](#).

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- Enrollees who do not meet a [six-month renewal exemption](#) must complete a renewal every six months.
- Income renewals must be processed by the end of the month before the six-month renewal month.
- Monthly renewal. A monthly review, also known as a monthly renewal, must be completed in specific situations. For more information see [Monthly Renewals](#).
  - Monthly renewals are due and processed in the month following the month for which eligibility is being determined.
  - People with monthly renewals must also complete an annual renewal unless they meet an exemption. The annual renewal is mailed by the system on the 15th of the second month before the annual renewal month.

### MA Pregnant Woman Renewal Requirements

All women who wish to continue MA coverage following the [60-day postpartum period](#) must update their income and asset information and submit required verifications.

- Collect the required information and verification upon notification of the birth.
  - Attempt to contact the woman by phone to gather the information.
  - If a telephone update is not possible send a MHCP Request for Information ([DHS-3271](#)).
  - Require verifications to be returned at least 20 days before the end of the postpartum period.
    - Request asset verifications if there are none on file or are older than six months.
    - Request income verification if the enrollee has new or increased earned income.
- **Do not** require additional information or verification if a completed [renewal form](#) has been received, including all required verifications, within the past six months.
- Determine continued eligibility in the last month of the postpartum period for the following month from information in the case record.
- Approve continued eligibility if the woman is eligible under another [basis of eligibility](#) and meets all other eligibility criteria.
- Close MA eligibility for the end of the postpartum period giving 10-day notice for women who:
  - do not meet another basis of eligibility.
  - are not eligible for another reason.
  - do not return requested information and/or verification.

### Determining the MA Annual Renewal Month

The renewal month is determined for a household as follows:

- The first annual renewal month after application is 12 months after the first month of the certification period.

Note: When members of a household apply at the same time but the [eligibility begin date](#) differs, assign the entire household the earliest renewal date.
- Subsequent annual renewal months are 12 months following the effective date of the last annual renewal month.

### Sending the Annual Renewal

The annual renewal is systematically sent for households who are not required to report monthly around the 15th of the second month before the month the renewal is due. The system determines which [renewal form](#) to send according to what programs the household receives.

Exception: The renewal form for [MA Breast and Cervical Cancer](#) enrollees is not sent automatically by the system.

Manually mail the MA-BC Application/Renewal Form ([DHS-3525](#)) and Certification of Further Treatment Required ([DHS-3525A](#)) to MA-BC enrollees on the 15th day of the second month before the renewal is due.

### Photocopied, Faxed and Scanned Renewals

Accept and process photocopied, faxed and scanned renewals. Do not require the client to submit the original renewal

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form.

### 2. Renewal Signature

Signatures from specific people are required for all renewals - annual, monthly and six-month.

#### Renewal Signature Requirements

Follow the policy in [Application Signature](#) to determine who needs to sign a renewal.

- Send a photocopy of the renewal form with the Request for Information ([DHS-3271](#)) to obtain the missing signatures.
- Eligibility will end for enrollees who have not provided required signatures by the renewal month.

(The following information appeared in 2 recent HealthQuest responses and thought worthy of mentioning here since this is an issue that older workers used to deal with, though not mentioned in HCPM:

Because renewals are mailed approximately 45 days prior to the renewal date, it is possible that the client could return the form more than 30 days prior to the renewal date. As such, there is no requirement that the client sign the renewal within 30 days of the renewal date.)

### 3. Monthly Renewals

Only MA has provisions for monthly reporting, also known as monthly renewals. MinnesotaCare does not have monthly renewals.

#### Who has a Monthly Renewal?

Require people to complete a Household Report Form (HRF) ([DHS-2120](#)) monthly only if they have an [LTC spenddown](#) with income changes each month.

#### Sending the Monthly Renewal

The HRF is automatically sent to households six working days before the end of the month the HRF covers.

#### When is the Monthly Renewal Due?

The household must submit the HRF and all mandatory verifications by the eighth day of the month following the month it covers.

- The system will send a Notice of Late or Incomplete Household Report Form or Health Care Renewal ([DHS-2414](#)) if the household does not submit the report on time, or it is incomplete.
- The system will send a 10-day notice of termination if the household does not submit the report by 10-day notice cutoff, or it is incomplete.
  - The case remains closed if the HRF has not been received by the end of the month.
  - Reinstate the case if the household returns the HRF before the end of the month and remains eligible.

### 4. Six-Month Renewals

MA enrollees, including Medicare Savings Program enrollees, are the only clients who must complete a six-month renewal.

#### Six-Month Renewal Requirements

MA enrollees must provide information about their income and assets every six months unless a six-month [income renewal exemption](#) or a six-month [asset renewal exemption](#) is met.

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Note: Enrollees who are exempt from completing a six-month income renewal are also exempt from completing a six-month asset renewal.

- The six-month renewal determines eligibility for the next certification period.
- Begin the first six-month period with the month of initial eligibility for all enrollees.  
Note: The six-month renewal will alternate every six months with the annual renewal.
- The completed six-month renewal form is due by the eighth day of the sixth month of the certification period.
  - The system will send a termination notice if the six-month renewal is not received by the 16th of the sixth month of the certification period.
  - The system will automatically close the case if the six-month renewal form is not received, or it is incomplete on the last day of the last month of the certification period.
  - Reinstate coverage if the six-month renewal form is received by the end of the sixth month and the household remains eligible.
- Verify all countable assets and their encumbrances for enrollees required to report assets.  
Note: Some enrollees are not required to report assets at the six-month renewal. See [Six-Month Asset Renewal Exemptions](#).
- Verify current income from the previous 30 days. Use the most accurate information available at the time of the six-month renewal.
- Redetermine MA eligibility.
  - Counties that are MinnesotaCare enrollment sites must determine MinnesotaCare eligibility if the client is no longer eligible for MA, unless the case was closed for failure to return the renewal or failure to provide verifications or requested information.

### Late Six-Month Renewals

A renewal is late if it is returned after the end of the [certification period](#).

Process the renewal as a new application if the complete renewal is received in the [renewal month](#). For MA, approve coverage back to the first day of the renewal month or the date [all eligibility factors are met](#).

Unless the household meets an exception under [Application Not Required](#), require a new application if the enrollee submits:

- a renewal after the renewal month.
- an incomplete renewal before the end of the certification period, but submits missing information/verifications after the end of the renewal month.

Note: If the client is [cooperating with obtaining verifications](#), do not require a new application.

- an incomplete renewal during the renewal month and the missing information is returned after the renewal month.

Exception: Safe at Home participants may request and be granted good cause for late submission or completion of renewals. See [Data Privacy](#) or the [Minnesota Secretary of State's Web site](#) for further information.

### Six-Month Renewal Forms

The following forms may be used for the six-month renewal:

- Combined Six-Month Report ([DHS-5576](#)).
- Renewal for People Receiving Long-Term Care Services ([DHS-2128](#)).
- Household Report Form (HRF) ([DHS-2120](#)). The HRF may be sent to some enrollees required to report monthly and can be used as the six-month renewal form.

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The system will generate and attach instructions to the appropriate six-month renewal form.

### Six-Month Asset Renewal Exemptions

The following people are exempt from a six-month asset renewal:

- People noted as exempt in [Exemptions from Asset Limits](#).

Reminder: A client who is exempt from the asset limit may still need to provide asset verifications if their assets are [deemed](#) to another household member.

- Enrollees who are exempt from completing a six-month income renewal.

Note: Update the case as needed, but do not deny coverage or require verification based on whether an enrollee who is exempt from six-month asset renewals answers or does not answer the asset questions on the Combined Six-Month Renewal Form.

### Six-Month Income Renewal Exemptions

The following people are exempt from completing a six-month income renewal:

- People who complete [monthly renewals](#) for MA, Food Support, or a cash program. Use the information on the monthly reports to complete the MA six-month income renewal if a client submits the monthly form. Request information and verifications as necessary if the monthly report does not contain enough information to determine MA eligibility.
- People who receive MA automatically with MSA or GRH.
- People who meet an annual [renewal exemption](#).
- People who receive **only** unvarying unearned income, such as:
  - RSDI.
  - Private pensions.
  - Veterans' benefits.
  - MFIP.
  - Other unvarying payments that are expected to continue indefinitely.
- People whose **only** source of income is from an excluded income source such as SSI.
- RMA enrollees.
- People who report no income.

Base eligibility on information in the case record or available from other sources, such as [BNDX](#) and [SDXS](#), when approving the new certification period for people exempt from the income renewal.

Require people with spenddowns who are exempt from income renewals to submit documentation of medical expenses if needed to determine continued eligibility for the next six-month budget period.

Review eligibility for enrollees who are exempt from an income renewal when they report receipt of lump sums or additional assets.

## 5. Processing MA Annual Renewals

This section provides information on processing an MA annual renewal.

For information on processing six-month renewals and monthly renewals, see [Six-Month Renewals](#) and [Monthly Renewals](#).

### What Is a Complete Annual Renewal?

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Clients must provide the following to consider the annual renewal complete and ready to be processed for eligibility:

- A completed renewal form. For more information on acceptable renewal forms, see [Renewal Forms](#).
- A signature for everyone required to sign. See [Renewal Signature](#) for specific policy on who must sign the renewal form.
- Required [verifications](#) and any information needed to redetermine eligibility.

Exception: Participants in the Safe at Home (SAH) Address Confidentiality Program are not required to provide their actual address.

### MA Annual Renewal Processing Steps

Follow these steps to process an MA renewal:

#### 1. Process renewals in the order they are received.

- If possible, process the renewal before the 10-day notice cutoff.
- Processing the renewal before the date for payment of managed care capitations will ensure continued managed care coverage.
- Do not require an in-person interview as part of the renewal process for MA.

#### 2. Review the renewal form.

- Review the renewal for missing data, [verifications](#) and the following:
  - Required [signatures](#).
  - Address changes.
  - Household member changes. See [Adding a Household Member](#) and [Removing a Household Member](#).
  - [Pregnancy](#) reported. Request verification. Consider the woman to be a pregnant woman when the pregnancy has been verified.
  - Insurance changes. Request new insurance information.
  - [Assets](#).
  - Income. Request verifications.
  - Changes in parental status and [medical support](#). Follow required steps.
  - Managed care status changes.

- Contact the enrollee to obtain any missing information or verifications.

Note: County agencies may request the reimbursement officer to obtain information necessary to renew the eligibility of Regional Treatment Center residents.

- Set the client's renewal status to 'I' (incomplete) on the REVW screen if information is missing.

#### 3. Update MAXIS with the new information.

#### 4. Redetermine MA eligibility.

- If the client has completed the renewal and sent in all required information and verifications timely and:
  - The client remains eligible, approve the renewal for the first of the [renewal month](#).

Note: Add a worker comment to the approval notice if MA-EPD is closing but the client remains eligible under another basis of eligibility or under another health care program. Include notice that MA-EPD is closing, the effective date of closure and the reason it is closing.
  - The client **is no longer** eligible, close eligibility for the end of the month before the renewal month using the appropriate closing reason.
    - Determine MinnesotaCare eligibility. Transfer the renewal to MCRE Operations if the county agency is not a MCRE enrollment site.
    - Add a worker comment to the closing notice if MA-EPD is closing. Include in the notice that MA-EPD is



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closing, the effective date of closure and the reason it is closing.

- MAXIS will generate a closing notice on 10-day cutoff in the month before the renewal month if information and verifications are incomplete (renewal status of 'I') or the renewal has not been received (renewal status of 'N').

Note: If the household turns in the renewal form before the last day of the certification period but after 10-day cutoff, and it is incomplete **or** the agency does not have time to act on the form before the end of the month, the case will remain closed. Reinstate MA coverage if the household submits the missing information during the renewal month and the agency determines that eligibility continues.

### Late Renewals

A renewal is late if it is returned after the end of the certification period.

Process the renewal as a new [application](#) if the complete renewal is received in the renewal month. For MA, approve coverage back to the first day of the renewal month or the date all eligibility factors are met.

Unless the household meets an exception under [Application Not Required](#), require a new application if the enrollee submits:

- a renewal after the renewal month.
- an incomplete renewal before the end of the certification period, but submits missing information/verifications after the end of the renewal month.

Note: If the client is [cooperating with obtaining verifications](#), do not require a new application.

- an incomplete renewal during the renewal month and the missing information is returned after the renewal month.

Exception: Safe at Home participants may request and be granted good cause for late submission or completion of renewals. See [Data Privacy](#) and the [Minnesota Secretary of State's Web site](#) for further information.

## 6. Annual Renewal Exemptions

Some enrollees are exempt from annual renewals for a certain period of time, or while using a specific basis of eligibility.

See [Monthly Renewals](#) and [Six-Month Renewals](#) for information on enrollees who are required to complete renewals more frequently than annually.

### Medical Assistance

The following people do not have an MA annual renewal until specified:

- Pregnant women. Renew eligibility for the month following the month in which postpartum ends.
- People receiving Transitional MA (TMA) or Transition Year MA (TYMA), unless a scheduled renewal is due when TMA/TYMA is ending.
- Title IV-E or State [adoption assistance](#).
- Auto newborns. Renew eligibility when the exemption ends. Renew for the month following the month of the first birthday.

## 7. Renewal Forms

The following forms are used during the renewal process:

- Minnesota Health Care Programs Renewal ([DHS-3418](#)).

This is the annual renewal form sent to most enrolled clients to gather eligibility information. Enrollees must complete and return it to continue eligibility.

- Enrollees provide data similar to what is requested on an application, including but not limited to the following information:
  - List of household members.



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- Income.
- Assets.
- Health insurance.
- Other changes.

- The DHS-3418:

- includes a medical release, along with the client's rights and responsibilities.
- may also be used to apply for household members not currently covered.
- may be used as an application.

- **Do not** require a DHS-3418 if the following forms are received instead:

- Combined Application Form (CAF) ([DHS-5223](#)).
- Renewal for People Receiving Long-Term Care Services ([DHS-2128](#)).
- Health Care Application (HCAPP) ([DHS-3417](#)).
- [ApplyMN](#) application requesting Medical Assistance, MinnesotaCare, cash assistance, Supplemental Nutrition Assistance Program (SNAP) or emergency assistance.

This form may be used as an application if received in the renewal month.

- Combined Application Form (CAF) ([DHS-5223](#))

The CAF is the annual renewal for people receiving cash assistance or SNAP. A person who is also receiving health care with these programs will be sent the CAF if the renewal date corresponds with the recertification date for SNAP and cash.

Contact the enrollee to request additional information if the CAF does not provide enough information to renew health care coverage.

- Renewal for People Receiving Long-Term Care Services ([DHS-2128](#)).

This is the form used to renew eligibility, both annually and at six months, for people residing in long-term care (LTC) facilities or receiving Elderly Waiver (EW) services. This includes LTC residents who receive MSA for personal needs and EW enrollees residing in GRH facilities and receiving GRH payments.

Note: This renewal form is also used when all MHCP household members receive services through a CAC, CADI, DD or BI waiver. The DHS-3418 is sent to the household if there is a household member who is not receiving services through one of these waiver programs.

The DHS-2128 may be used as an application for MA, including payment of LTC services, if received in the renewal month.

- Health Care Coverage Options in Minnesota brochure ([DHS-3416](#)).

Send this form to clients who have questions about the different public and private health care options available to residents of Minnesota.

- MA-BC Application/Renewal ([DHS-3525](#)) and Certification of Further Treatment Required ([DHS-3525A](#)).

These two forms are used exclusively for MA Breast and Cervical Cancer enrollees to renew coverage. **Do not** require these forms if another renewal form is received.

- Household Report Form (HRF) ([DHS-2120](#)).

This form is used when a client is required to renew eligibility monthly. See [Monthly Renewal](#) for more information on monthly reporters.

This form may **not** be used as an application or as an annual renewal. It may be used as a six-month renewal.

- Notice of Late or Incomplete Household Report Form, Health Care Renewal Form or Combined Six-Month Report

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([DHS-2414](#)).

Send this notice to clients when their benefits are being terminated because they failed to return the required report form or the form was not completed correctly. The back of the form lists the client appeal rights information.

- Combined Six-Month Report ([DHS-5576](#)).

This form is sent to MA clients for their [six-month renewal](#) and MA clients for their income and asset six-month renewal. This form may be used as an application for MA if received in the renewal month.

### 8. ApplyMN Applications Received at Renewal (ApplyMN Worker Process Guide)

Accept an ApplyMN application as a renewal if received within the renewal processing period and update the appropriate systems following current program policy. Treat new requests for programs on the application as a new request for assistance, using the application date as the date of request. Follow-up with the client for verifications, forms, or other information needed to process the renewal.

Process ApplyMN applications submitted during the renewal processing period that contain a request for a new type of assistance as a new application for that program.

### 9. POLI/TEMP: STAT/RE VW - HC - TE09.07.05

#### IMPORTANT - RENEWAL FORMS MAILING/AUTOCLOSE PROCESS

MAXIS uses the renewal dates to determine when to mail renewal forms. Mailing the forms sets up the conditions for the case to display in REPT/RE VW, the sending of an autoclose notice, and the autoclosure of the case. Renewal forms are mailed on the 15th of each month for the renewal that is due approximately 45 days in the future.

**References:** Include links to HCPM sections, DHS web, bulletins or other relevant documentation of current policy.

[HCPM 08.25](#) - MA Renewals  
[HCPM 08.25.05](#) - Processing MA Annual Renewals  
[HCPM 08.30](#) - Monthly Renewals  
[HCPM 08.35](#) - Six-Month Renewals  
[HCPM 08.05](#) - Annual Renewal Exemptions  
[HCPM 08.10](#) - Renewal Forms  
[HCPM 08.15](#) - Renewal Signature  
 POLI/TEMP TE09.07.05 STAT/RE VW - HC  
[ApplyMN Worker Process Guide \(Apps Received at Renewal\)](#)  
 HealthQuest #s 13618 & 14521

### ‘TO BE’ POLICY ASSESSMENT UNDER ACA

ACA Citations <i>List citation and link to underlying authority or embedded PDF</i>	Plain Language Synopsis of Citations
<a href="#">42 C.F.R. 435.916</a>	<p>Eligibility for MAGI-eligible enrollees must be redetermined every 12 months and no more frequently than every 12 months. Eligibility for non-MAGI eligible individuals must be redetermined at least every 12 months.</p> <ul style="list-style-type: none"> <li>• The Medicaid agency must redetermine eligibility without requiring additional information from the individual if it can do so based on reliable information available in the individual’s account or other information available to the agency.</li> <li>• If the agency can renew eligibility based on available information, the agency must notify the individual of the eligibility determination, the basis of the determination, and that the individual must inform the agency of any inaccurate information contained in the notice.</li> </ul>

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### Prepopulated Renewals – Mandated for MAGI, Optional for Non-MAGI

- If the agency cannot renew eligibility based on available information, it must provide the individual with a renewal form pre-populated with information available to the agency.
  - The individual has at least 30 days from the date of the renewal form to provide any requested information and sign the renewal form before returning it to the agency.
  - The agency must provide the individual with a notice of any eligibility decision related to renewal
  - The agency must verify any information provided by the individual as required by 435.945 through 435.956.
- The agency must give timely reconsideration of eligibility to individuals who fail to return the pre-populated renewal form but subsequently submits the renewal form within 90 days after termination (the State may elect a longer period) without requiring a new application. (Mandated for MAGI, optional for non-MAGI.)
- The agency must consider all bases of eligibility before determining an individual ineligible for Medicaid.
- When an individual is determined ineligible for Medicaid, the agency must determine eligibility for other insurance affordability programs and transfer the individual's electronic account as appropriate.
- The agency may consider a blindness or disability as continuing until the reviewing physician or team determines that the condition no longer meets the definition of blindness or disability.

### Reporting Changes

- The agency must have procedures in place to ensure that individuals report changes that may affect eligibility. Changes may be reported electronically, by mail, by phone, or in person.
- The agency must promptly redetermine eligibility when an individual reports a change.
- For renewals of MAGI-eligible individuals, the agency must limit any request for additional information to information related to the change reported by the individual.
- If the agency has information on anticipated changes that may affect an individual's eligibility, the agency must redetermine eligibility at the appropriate time based on those changes.

### Rolling Renewals Option

- The agency may create a new 12-month eligibility period if the agency has enough information to renew eligibility when a change is reported.

### Requests for non-applicant information

- Requests for non-applicant information must be in accordance with 435.907(e) (voluntary request for non-applicant's Social Security number)

### ADA/LEP Notice Requirements

- Any renewal form or notice must be accessible to persons with limited English proficiency and people with disabilities.

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<a href="#">CFR 435.908</a> and commentary from page 17163.	<p><b>§ 435.908</b> Assistance with application and renewal.</p> <p>(a) The agency must provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient.</p> <p>Commentary: We clarify that application and renewal forms meet the same accessibility standards at § 435.907(g) and § 435.916(g).</p>
<a href="#">Exchange Final Rule</a> , 45 CFR § 155.335	<p>Provides the regulations on the annual redetermination process for individuals enrolled in a QHP through the Exchange.</p>
<a href="#">Final Treasury Rule</a> 1.36B-2(c)(3)(v)(A)(3)	<p>An employer-sponsored plan is not affordable for the employee if the Exchange determines that the eligible employer-sponsored plan is not affordable for the benefit year. This only applies if the enrollee/application filer affirmatively responds to the annual redetermination notice and provides current information on affordability. (The safe harbor provision also does not apply to an enrollee/application filer who, with reckless disregard for the facts, provides incorrect information to the Exchange.)</p>
<b>'To Be' Policy</b>	
<b>MAGI</b>	<p>MAGI Medicaid enrollees must have their Medicaid eligibility redetermined once every 12 months and no more frequently than once every 12 months.</p> <p>See the <a href="#">timeline</a> document for information on the schedule and timing of events related to the renewal process. See the <a href="#">Renewal Process flow</a> documents for specific processes for MAGI, APTC/CSR and QHP-only.</p> <p>The <b>first step</b> of the renewal process requires the agency to determine if an enrollee's coverage can be renewed based on information available to the agency. Prior to contacting the enrollee, the agency must determine if it can renew Medicaid eligibility based on reliable information contained in the enrollee's account or other more current information available to the agency. See the <a href="#">auto processing</a> document for further information.</p> <ul style="list-style-type: none"> <li>• If eligibility can be renewed, the agency must renew coverage for the next certification period and provide notification to the enrollee.             <ul style="list-style-type: none"> <li>○ The agency must notify the enrollee that coverage has been renewed, and how the agency arrived at that determination. This will include a summary of the data, as well as its source, that was used in the eligibility determination.</li> <li>○ The notice must provide information on fair hearings/appeal process following standard guidelines for notices.</li> <li>○ The notice must instruct the enrollee to inform the agency if any information contained in the notice is inaccurate. The enrollee can inform the agency via any of the same modes allowed when <a href="#">submitting an application</a>.</li> </ul> </li> </ul> <p>Note: There are no special procedures for reporting changes associated with a renewal. If changes are reported, it follows standard guidelines for <a href="#">changes</a>.</p> <ul style="list-style-type: none"> <li>○ The agency must follow standard policy for establishing the enrollee's next renewal date.</li> <li>○ The enrollee is <u>not</u> required to sign and return the notice.</li> </ul>

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- If all information used to determine eligibility is accurate, no further action is needed in regards to the renewal process; the enrollee's renewal has been completed.

- If eligibility cannot be renewed, the agency must send out a renewal form to the enrollee. The renewal form must be [pre-populated](#) with information available to the agency that is needed to renew eligibility. The agency must provide the enrollee a period of at least 30 days from the date of the renewal form to respond and provide any necessary information and sign. The pre-populated renewal form may be sent via mail or via an electronic version if an enrollee has selected that option as the method to receive correspondence (notices, forms, verification requests, etc.)

Note: Eligibility may not be renewed automatically (and a pre-populated form sent) if enrollee is open on MAGI Medicaid but does not have continued eligibility based on electronic sources at the time of the renewal and must be determined for other IAPs, or when electronic sources are unable to gather the necessary information to complete the renewal process. Also see [Client Notices](#). Dynamic notice text must be provided to streamline the renewal process – informing the enrollee of all available program options and requirements at each step of the renewal process when a notice is required.

- The enrollee can provide this information via any of the same modes allowed when [submitting an application](#).
- The enrollee must sign the renewal. The enrollee can provide this signature via any of the same modes allowed when [signing](#) an application.
- The agency must provide the enrollee with a cancellation notice, along with the pre-populated renewal form, stating that coverage will end at the end of his/her current certification period due to an incomplete renewal unless the agency can determine he/she continues to meet the eligibility requirements. The enrollee will need to complete the renewal form, sign it, and provide any information needed to redetermine eligibility.
- The cancellation notice must provide information on fair hearings/appeal process following standard guidelines for notices.
- No further action is needed unless the enrollee returns the signed renewal.

The **second step** of the renewal process begins if the enrollee returns the signed pre-populated renewal prior to the end of his/her current certification period.

Note: If the enrollee responds after his/her certification period ends, follow the policy for [late renewals](#) to determine if a new application is needed in order to determine eligibility.

If the enrollee responds to the renewal, eligibility is redetermined using information provided on the returned renewal.

- If enrollee remains eligible for Medicaid, the agency must renew coverage for the next certification period and provide notification to the enrollee.
- If enrollee is determined ineligible for Medicaid, the agency must issue a cancellation notice with the specific reason why the enrollee was determined ineligible. Coverage will continue to end at the end of the current certification period. The cancellation notice must provide information on fair hearings/appeal process following standard

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	<p>guidelines for notices.</p> <p>Note: Advance notice requirements are not applicable to this notice since the enrollee was already provided with a cancelation notice when he/she was sent the pre-populated renewal form.</p> <p>The agency must make an eligibility determination for all other insurance affordability programs following standard policy.</p> <ul style="list-style-type: none"> <li>If the agency is unable to redetermine eligibility because the renewal remains <a href="#">incomplete</a> (because not all of the needed data was provided, the renewal wasn't signed, or needed verification was not provided), the agency must issue a notice requesting the needed information. The information must be received by the last business day prior to the end of the current certification period in order for eligibility to be redetermined and, if coverage can be renewed, avoid a lapse in coverage.</li> </ul> <p>Note: If the enrollee responds after his/her certification period ends, follow the policy for <a href="#">late renewals</a> to determine if a new application is needed in order to determine eligibility.</p>
<b>Non-MAGI</b> (Applies Across Medicaid)	Follows MAGI policy regarding <a href="#">auto processing</a> to see if coverage can be renewed on the basis of information available to the agency prior to contacting the enrollee. Agencies have the option to adopt the use of the pre-populated renewal. Otherwise, no other changes unless the non-MAGI renewal process is aligned with MAGI. If so, then it would follow MAGI.
<b>Advanced Premium Tax Credits</b>	Follows renewal policy for Qualified Health Plans.
<b>Cost Sharing Reductions</b>	Follows renewal policy for Qualified Health Plans.
<b>Qualified Health Plans</b>	<p>The Exchange must redetermine the eligibility of an enrollee enrolled in a QHP through the Exchange on an annual basis.</p> <p>If the enrollee requested an eligibility determination for insurance affordability programs, the Exchange will redetermine eligibility for all insurance affordability programs as long as an authorization to release tax return data is active. See <a href="#">authorization documentation</a> for further details on the tax authorization.</p> <p>Note: An enrollee may have indicated their request for IAPs in a prior year (not necessarily from the most recent request on the Exchange). If an "active" request for IAPs is still tracked, all IAPs will be determined if an authorization to release of tax return data is also active.</p> <p>Note: If the enrollee had requested an eligibility determination for insurance affordability programs and an authorization to release tax return data is not active, the Exchange must notify the enrollee. The Exchange cannot proceed with the redetermination until such authorization has been obtained or the enrollee discontinues his or her request for an eligibility determination for insurance affordability programs.</p> <p>The <b>first step</b> of the renewal process requires the Exchange to mail an annual redetermination notice to the enrollee.</p> <ul style="list-style-type: none"> <li>The notice must include the following data: <ul style="list-style-type: none"> <li>If the enrollee requested an eligibility determination for insurance affordability programs and an authorization to release of tax return data is active, data regarding income and family size obtained from the updated tax return</li> </ul> </li> </ul>

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information received from the federal data hub.

- Data used in the most recent eligibility determination
  - The enrollee's projected eligibility determination for the following benefit year
- The Exchange must consolidate the annual redetermination notice and the notice announcing the annual open enrollment period into one notice for at least the first two years of operations.
  - For redetermination of coverage effective 01/01/2015, the Exchange must send the consolidated notices no earlier than September 1, 2014, and no later than September 30, 2014.
  - For redetermination of coverage effective 01/01/2016, the Exchange must send the consolidated notices no earlier than September 1, 2015, and no later than September 30, 2015.
  - For redetermination of coverage effective 01/01/2017 or later, the Exchange can either:
    - continue to issue a consolidated notice no earlier than September 1 and no later than September 30; or
    - Issue separate notices. The notice announcing the annual open enrollment period must be issued no earlier than September 1 and no later than September 30. The annual redetermination notice can be sent no earlier than the date the notice announcing the annual open enrollment period was issued. It can be sent no later than a "reasonable" amount of time for the enrollee to review the notice, provide a timely response, and for the exchange to implement any changes in coverage elected during the annual open enrollment period.
- The Exchange must request an enrollee, or an application filer acting on behalf of the enrollee, to report any changes with respect to the information on the annual redetermination notice, and sign it and return it to the Exchange.
  - The due date is 30 days from the date of the notice.
  - The Exchange must allow for the enrollee or an application filer acting on behalf of the enrollee, to report changes via any of the same modes allowed when [submitting an application](#).
  - The Exchange must clarify the reported changes (as needed) and verify any changes reported by an enrollee following the same verification process, including the relevant provisions of the inconsistent information process, used for an initial application prior to using the information to determine eligibility. If the Exchange must follow the inconsistent information process (see 155.315(f)) to verify the enrollee's reported change it must send a notice to the enrollee requesting verification. The verification is due Nov. 7.
- If an enrollee does not sign and return the notice by the due date, the Exchange must proceed with the second step of the renewal process once the 30-day period has elapsed.

Note: We will need to identify and track individuals who did not return their renewal. There is an employee safe harbor provision regarding the eligibility



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	<p>for a premium tax credit. An employer-sponsored plan is not affordable for the employee if the Exchange determines that the eligible employer-sponsored plan is not affordable for the benefit year. This does not apply unless the enrollee/application filer affirmatively responds to the annual redetermination notice and provides current information on affordability. (The safe harbor provision also does not apply to an enrollee/application filer who, with reckless disregard for the facts, provides incorrect information to the exchange.)</p> <p>The <b>second step</b> of the renewal process requires the Exchange to redetermine eligibility using the information provided on the annual redetermination notice as supplemented with any information reported by the enrollee and verified by the Exchange. This cannot be completed until all changes reported by the enrollee have been verified or, as of November 7, eligibility will be based on stored data verified by the hub and new verified data provided by the enrollee.</p> <p>Once eligibility has been redetermined the Exchange must:</p> <ul style="list-style-type: none"> <li>• Issue an eligibility notice to the enrollee following standard guidelines.</li> <li>• If the tax payer has been determined eligible for APTC or CSR, issue a notice to the tax payer's employer following standard guidelines.</li> </ul> <p>If the Exchange cannot verify the changes reported by the enrollee by the due date the Exchange will determine eligibility based on the information in the redetermination notice. If the enrollee later provides verification, the Exchange will treat it as a reported change.</p> <p>Exceptions to the Inconsistencies Process:</p> <ul style="list-style-type: none"> <li>• If the enrollee qualified for an alternate verification process, tax return data was available, the enrollee's attested income was more than 10% below the tax return income, income could not be verified using alternate electronic sources, the enrollee did not return the requested verification, and the tax return data shows that an applicant in the tax filer's family is eligible for Medicaid, then the Exchange cannot redetermine IAP eligibility for the enrollee.</li> <li>• If the enrollee qualified for an alternate verification process, tax return data was unavailable (define), income could not be verified using alternate electronic sources, and the enrollee did not return the requested verification, then the Exchange cannot redetermine APTC/IAP eligibility for the enrollee.</li> </ul> <p style="text-align: center;">Note: Tax return data is unavailable if the Secretary of the Treasury does not have tax return data that may be disclosed for purposes of determining IAP eligibility for the tax filer that is at least as recent as the calendar year two years prior to the calendar year for which APTC or CSR would be effective.</p> <p>The effective date of the redetermination is the first day of the coverage year following the year in which the Exchange issued the annual redetermination notice or the effective date following standard <a href="#">begin &amp; end date</a> policy, whichever is later.</p> <p>If an enrollee remains eligible for coverage in a QHP, the enrollee will remain enrolled in the QHP unless the enrollee terminates from such plan, following standard termination of coverage policy.</p>
<b>Individual Insurance Requirement Exemption</b>	N/A

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How will the 'to be' policy affect or apply to:	
<b>New applicants</b>	N/A
<b>Current Enrollees</b>	For enrollees already on Medicaid on or before December 31, 2013, the use of the MAGI methodology begins March 31, 2014, or the next regularly scheduled renewal, whichever is later. Thus, redetermination of Medicaid enrollees whose financial eligibility is based on the MAGI methodology will begin with April 2014 renewals.
<b>Application Process</b>	N/A
<b>Eligibility Begin Date</b>	N/A
<b>Renewals</b>	Addressed in the "To Be" policy.
<b>Verification Requirements</b>	Follow verification requirements as listed in renewal policy above.
<b>Social Security Number</b>	N/A
<b>Citizenship Status</b>	N/A
<b>Immigration Status</b>	N/A
<b>Insurance, TPL &amp; Benefit Recovery</b>	N/A
<b>State Residency</b>	N/A
<b>Household Composition</b>	N/A
<b>Income and Asset Guidelines</b>	N/A
<b>Income and Asset Deeming</b>	N/A
<b>Income Calculation</b>	N/A
<b>Spenddowns and Obligations</b>	N/A
<b>Premiums</b>	N/A
<b>Covered Services</b>	N/A
<b>Service Delivery</b>	N/A
<b>End of Eligibility</b>	N/A
<b>Other Requirements</b>	N/A
<b>Relationship to Other Programs, Groups or Bases</b>	N/A
<b>Other Reference Material</b> <small>Include links to flowcharts, tables, issue briefs, etc.</small>	<a href="#">Renewal Process Flow</a> documents

<b>Change in State Law Needed?</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Detail of State Law Change</b>	
Align state law with new renewal process.	
<b>Federal Compliance Considerations?</b>	<input type="checkbox"/> State Plan Option <input type="checkbox"/> Waiver <input type="checkbox"/> Other <input checked="" type="checkbox"/> None
<b>Detail of Federal Compliance Considerations</b>	